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ABSTRACT

A 4-day seminar attended by faculty primarily from midwestern junior colleges, senior colleges, and related institutions, was offered to provide instruction in the use of task analysis for curriculum development. Seminar activities included panel discussions, small group work sessions, field trips, and major presentations dealing with task analysis, experimental and clinical evidence for including child development courses in the child care curriculum, group care of infants, educational and health components in child care, and training for role differentiation. Some of the seminar activities are summarized, and a curriculum outline for child care personnel, film list, bibliographies, and other materials are appended. (SB)

Phase II Final Report

REPORT OF SEMINAR

IN "CURRICULUM FOR

CHILD CARE TRAINING"

Prepared by Barry S. Warren

Project No. 7-0329
Grant No. OEG-0-8-070329-3694 (085)
SOCIAL SERVICE AIDE PROJECT
For the Training and Education
of Paraprofessionals

September 30, 1970

Career Options Research and Development
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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Office of Education
Bureau of Research

SEMINAR ON "CURRICULUM FOR CHILD CARE TRAINING"

During the week of June 15-19, 1970, a seminar in curriculum development for Child Care was held at the Sheraton-Chicago Hotel. The seminar was hosted by Dr. Joan Swift and the Human Services Institute of the Chicago City College System and funded by a grant from the Health, Education and Welfare Department of the United States. It was attended by Dr. Swift, Barry Warren of SSAP (CORD), and a variety of faculty and administrative representatives from primarily midwestern junior colleges, senior colleges, and related institutions and structures. (See appendix A-List of Participants-at the end of this report). One representative came from as far away as Newton, Massachusetts and another from Greensboro, North Carolina.

BACKGROUND

This seminar was an outgrowth of two earlier events: the Sidney Fine Workshops, and a March 1970 meeting of the American Association of Junior Colleges (A.A.J.C.) in Chicago [Dr. Swift and C.C.C. were hosts]. It should be noted here that, although Dr. Swift and her staff participated in SSAP's Phase I Task Analysis, her lack of understanding of the technique was a handicap. Her subsequent participation in the Workshop #2 (See report on "The Systems Approach...A Workshop Experience"), greatly increased her understanding and enthusiasm for the use of functional task analysis and the systems approach for a variety of tasks, including curriculum development. At the A.A.J.C. Conference in March, 1970, she thus began to advocate use of these methods for curriculum development. Since plans for the Seminar on Child Care Curriculum grew out of the A.A.J.C. Conference, it was assumed that task analysis techniques would be central.

These developments were parallel and independent of Dr. Kassel's efforts to "corral" the colleges and agencies into the MESHS Conference. It was obvious to SSAP (CORD) staff that the junior colleges were resisting Dr. Kassel's invitations of cooperation and were giving no more assistance than required by public relations and common courtesy.

In addition to holding the Conference and Seminar, the colleges were initiating relationships with public and private agencies quite independently of Dr. Kassel's plans to bring them together. An example of this could be found in the Chicago City College's (C.C.C) relationships to the Chicago Committee on Urban Opportunity (CCUO). Dr. Swift and the Human Services Institute of the Chicago City College System had forged a direct relationship with CCUO through its director Mrs. Muriel Syler. The intrusion of Dr. Myrna Kassel and the Human Services Manpower Career Center (HSMCC) into this relationship is known to have caused dismay and unhappiness within the CCC system, and there is some evidence that it had a similar effect on CCUO.

SSAP (CORD) PARTICIPATION

Despite HSMCC interference, Dr. Swift continued with her own plan of action and sought to involve SSAP (CORD) in the Child Care Seminar to provide instruction in use of task analysis for curriculum development.

SSAP (CORD) had maintained a relationship with the Chicago City College System [See Phase I final report, Phase II quarterly reports, and Phase II final report, Pilot B Evaluation]. In Phase II, the relationship had become sub-contractual and had been designated Pilot "B". As the SSAP (CORD) liaison to Pilot "B", Mr. Warren was asked to represent SSAP(CORD) in the seminar. His position with Pilot "B" and his sharing of the Fine Workshop experience with Dr. Swift made the participation in the Seminar an easy and amicable affair. Since he had supervised the task analysis and subsequent data processing in the last stages of Phase I, Mr. Warren was asked to speak to the seminar participants on the topic: A Task Analysis Approach to Curriculum Development.

Mr. Warren's speech was well received and for the remainder of the seminar a smaller workgroup of about six people was assigned to take a closer look at the technique of curriculum development by task analysis. Both before and after his talk, Mr. Warren was approached by many participants with enthusiastic inquiries about the task analysis and Pilot "B" - a result of Dr. Swift's advocacy.

Many of those present stated that they needed just such a methodology for increasing the relevance of the curriculum offered in their schools and as a means for avoiding many of the inadequacies of present curriculum development methods. By the end of the talk, a commitment was formed with the participants to remain in touch with Mr. Warren, and SSAP(CORD), and to reconvene at some future date to explore in greater detail the application of task analysis to curriculum development. This committment was particularly strong for several of the participants from schools in Illinois and close to Chicago.

PROGRAM

Other speakers were included on the program, and Appendix B of this report provides the program schedule and topics for the seminar. Appendix C: the Curriculum Guidline for the Chicago Training Project for Childcare Personnel is highly recommended. It was presented by Mr. Robert E. Larkin of the Chicago City College System. Mr. Larkin is reputed to be one of the most competent and effective teachers within the Chicago City College System and his work is of great interest. Appendix D lists the films made available during the seminar; "Growth Failure" was particularly outstanding. Appendix E lists publications available for examination and purchase.

The most interesting talks were those given on the second day by Dr. Maria Piers of the Eric Erikson Institute for Early Education and on the last day by Dr. Robert S. Mendelsohn, Associate Professor, Department of Pediatrics, University of Illinois Medical School. The talk by Dr. Piers focused on experimental and clinical evidence for including Child Development courses in Child Care curricula. She established that an

important basis for planning curricula is the research and study of the needs and problems of the client population. This curriculum building input does not oppose, but is supplemented by, task analysis and research into what is being done and what actually gets done by the workforce.

Dr. R.S. Mendelsohn's talk deserves special attention in this report, because it dealt indirectly with one of the outstanding features of SSAP Phase I curriculum namely the Human Biology I and II courses in Principles of Health and Health Care. Dr. Mendelshon spoke with all the prestige and authority of a prominent figure in medical practice, research, and education, but he might as well have been a staff member of SSAP (CORD) for everything he said agreed with SSAP"S findings, and indicated our own course in development. Appendix F lists resource materials suggested by Dr. Mendlesohn with a sample of at least one of them, while Appendix G provides a transcript of testimony delivered by Dr. Mendelsohn to an Illinois Senate Appropriations Committee hearing on May 11, 1970. Below shall be listed a point by point summary of the information provided by Dr. Mendelsohn to the seminar:

(1) In no medical school that Dr. Mendelsohn is aware of is even a fraction of adequate attention given in the curriculum to nutrition and the effects of nutrition. Few medical schools teach separate courses on the subject of good nutrition. Of those that do, none offer more than 5 hours on the subject out of a thousand hours of other subjects.

(2) Far more than the general public appreciates, malnutrition or faulty nutrition is at the root of many degenerative diseases, most cogenital defects and diseases, most premature births and deaths, and increased succeptibility to infectious diseases.

(3) Many other conditions are brought about by the misfortunate use of drugs and other chemical agents in food, in medicine, and in the environment.

(4) Most doctors are nearly totally ignorant on the subjects of food, vitamins, and minerals and transmit faulty information, or worse, on these topics. Most doctors also have large gaps of ignorance on the effects of many of the drugs in common use.

(5) Increasing the number of doctors may actually decrease the level of good health in the general population and among the poor especially. He cited evidence from doctor's strike in Saskatchewan, Canada several years ago during which the general health of the population improved.

(6) The Medical crisis presently afflicting America benefits the M.D.'s. AMA membership and its learning benefit financially from the M.D. shortage. The Most severe harm takes place in the poor areas, since doctors gravitate to serving rich communities.

(7) M.D.'s are not the only ones who can do the job. A University of Illinois project shows nurses can perform diagnosis, treatment, examinations, and prescriptions as well as doctors -- at less cost, in less time, and sometimes doing it better. Legal protection was given the nurses in the project by stating that they were working under a doctor's supervision, but in actual fact they seldom, if ever, required consultation or assistance.

(8) A research study (Denver) shows that when parents, teachers, nurses, and doctors are compared, teachers were able to spot and diagnose more diseases and defects in children than any of the others. Parents come next, then nurses. Doctors did worst, in spite of being the only ones licensed to examine patients.

(9) University of Illinois research shows that for every year a doctor is in medical school, his skill and capacity to interview patients decreases markedly. By graduation, his skills in this important diagnostic area of interviewing have decresead almost to zero.

(10) Serious questions may be raised about whether medical schools are meeting present needs and about the relevance of curricula designed to help meet those needs. Medical schools may be part of the problem rather than the cure.

(11) Paraprofessionals may be more vital than doctors. In Uganda, one doctor with a battery of paraprofessionals succeeded in raising the national health level from a very low position in the world to a position on a par with the U.S.A., although still not top (See Jelliffe, Child Health In Uganda or Child Care in the Tropics).

(12) Pattern of early death amongst children in West Indies were changed by the same doctor who persuaded mothers to breast feed their babies. Fewer infants died when breast fed.

(13) Nutritionists frequently know no more than doctors about good nutrition, due to inadequate and misinformed schools. Experiment has shown that the average ghetto mother knows more about good nutrition than nutritionists. Equal numbers of ghetto mothers and Nutritionists were each given $20.00 and asked to buy food for one week for a fixed family size. Ghetto mothers purchased more nutritious and less expensive food. Nutritionists bought less nutritious, more expensive, and less essential foods.

(14) Much that Americans believe about medicine and drugs is the result of propaganda emanating from the AMA, pharmaceutical companies, and pharmaceutical societies.

(15) Statistics on death [he gave statistics] show that doctors are not recognizing and dealing with major causes of death among the young, and that they have chosen to focus their attention only on the smaller number of more expensive diseases that afflict older (and usually richer) patients. Further statistics show that the poor were more likely to

to die at all ages than the rich, and diseases of the poor have a strong nutritional basis.

In these and other points that he made, Dr. Mendelsohn indicated increasing paraprofessional services in the health field to do what doctors and other professionals cannot do. The Human Biology courses become, in the light of his talk and SSAP research, corner stones in the core curriculum foundation. Information is transmitted in those courses which medical schools have not recognized, but which meet pressing community needs and indeed national health needs. Dr. Mendelsohn went on to say that he had found that young people understood what he was saying much better than old, and that young people seem to have recognized his facts and the problems long before he and other older people did. To which we can say SSAP(CORD) curriculum prodated this particular talk of his by at least one year.

APPENDIX A

LIST OF PARTICIPANTS

SEMINAR IN CURRICULUM FOR CHILD CARE TRAINING

June 15-19, 1970

SEMINAR IN
CURRICULUM FOR CHILD CARE TRAINING
June 15-19, 1970

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APPENDIX B

PROGRAM AND SCHEDULE

SEMINAR IN CURRICULUM FOR CHILDCARE TRAINING

June 15-19, 1970

SEMINAR ON CURRICULUM FOR CHILD CARE TRAINING

HUMAN SERVICES INSTITUTE - CITY COLLEGES OF CHICAGO

Sheraton-Chicago
June 15-19, 1970

MONDAY - June 15, 1970

9:00 Registration - Lake Erie Room

9:30 General Session:
Greetings:

Introduction of Participants

Introduction to the Seminar: Purpose and Scope
Joan W. Swift

Panel Presentation - Sample Training Programs:

One Week Head Start Orientation

Four Week Schome Preservice Training

Twelve Week Child Care Training Program

One year Core Curriculum - Associate Degree Program

12:00 Lunch - Lake Ontario Room

1:30 Panel Presentation - The Consumers Speak: Students and Employers

2:30 Identification of Issues for Workshop Consideration

3:15 Research Report: A Task Analysis Approach to Curriculum Development

Barry Warren, Program Associate/Research Analyst
YMCA - Career Options Research and Development

4:00 Review and Planning Session

TUESDAY - June 16, 1970

9:00 Workshop group registration

9:30 General Session: Lake Erie Room

Speaker: Dr. Maria Piers, Erikson Institute for Early Education

Child Development - The Essential Ingredient in Child Care Training

10:45 Coffee

11:00 Workshops meet - Session I - Lake Erie and Lake Huron Rooms

12:30 Break for Lunch

1:30 General Session - Lake Erie Room

Research Report: Group Care of Infants

Speaker: Dr. Mary Elizabeth Keister, Director
Demonstration Project: Group Care of Infants
University of North Carolina

Discussion

3:00 Break

3:15 Workshops meet - Session II

WEDNESDAY - June 17, 1970

9:00 General Session

10:30 Coffee

11:00 General Session:
Speaker: Dr. Bernard Spodek, Department of Education, University of Illinois
The Educational Component in Child Care

12:30 Break for Lunch

1:30 Training for Role Differentiation?
Professionals - Paraprofessionals
Margaret Cline, Head Start Consultant

2:30 Panel on Curriculum I: Sample courses
The Core Curriculum

3:30 Workshops meet

THURSDAY - June 18, 1970

9:00 Visits to Laboratory Schools

1:30 General Session

Curriculum II: Sample Courses
Methods Courses in Child Care Training

3:00 Coffee

3:15 Curriculum III: The Practicum in Child Care Training

4:00 Workshops meet

FRIDAY - June 19, 1970

9:00 General Session -

Speaker: Dr. Robert S. Mendelsohn, Associate Professor Department of Pediatrics, University of Illinois Medical School

Health Component in Child Care Training

10:45 Coffee

11:00 Workshops meet

12:00 Lunch

1:30 General Session

Workshop Groups Report

APPENDIX C

CURRICULUM GUIDELINE

CHICAGO TRAINING PROJECT FOR CHILD CARE PERSONNEL

June 15-19, 1970

Human Services Institute
Robert E. Larkin
City Colleges of Chicago

CURRICULUM GUIDELINE

C W L A CHICAGO TRAINING PROJECT FOR CHILD CARE PERSONNEL

Course: UNDERSTANDING CHILD BEHAVIOR

I. The Normal Growth and Development of Children

1. The Developmental Task Concept.
   a) Origin of tasks:
      i) Biological system
      ii) Sociological system
      iii) Psychological system
   b) Cycle of development:
      i) Tasks of infancy and early childhood
      ii) Tasks of middle childhood
      iii) Tasks of adolescence
2. Facilitating Growth and Development through a Basic Insight and Understanding of These Tasks:
   a) Detecting emergence and recession
   b) Acquiring the sense of timing
   c) Being supportive and learning not to intensify problems
   d) Understanding temporary maladjustments
3. An Overview of Normal Growth and Development
   a) Differentiation between physical, intellectual, emotional, and social growth
   b) The meaning of maturation and learning
   c) Heredity, environment, and self-structure

II. Human Needs - The Dynamic Forces Involved in Behavior

1. The Biological Needs
   a) Visceral needs
   b) Safety needs
   c) Sex needs
   d) Sensory and motor needs
2. The Psychosocial Needs
   a) The needs for interpersonal satisfactions
   b) The needs for group status
   c) The needs for self-development

III. Problems of Adjustment

1. Stress:
   a) Frustration
   b) Conflict
   c) Pressure
2. Hyperemotional and Hypoemotional States
3. Defense Mechanisms
   a) Mechanisms of Deception
   b) Mechanisms of Substitution
   c) Mechanisms of Avoidance

4. Utility of Mechanisms
   a) Adjustive and Dysfunctional use
   b) Criteria for adjustive use

IV. The Child with Unmet Needs

1. Normal vs. Abnormal Behavior
2. Origin of Abnormal Behavior
   a) Fixation
   b) Regression
   c) Distortion

V. Major Factors Affecting Development and Behavior

1. Heredity
2. Mothering in Infancy
3. Physical Care
4. Love and Acceptance
5. Protection - Underprotection - Overprotection
6. Opportunity and Stimulation
7. Structuring of Order and Discipline
8. Guidance and Assistance
9. Success and Recognition
10. Early Frustration and Trauma

VI. The Family and Its Role in Child Development

1. The Developmental Tasks of the Family in all social classes and Subcultures
   a) Physical maintenance
   b) Allocation of resources
   c) Division of labor
   d) Socialization of family members
   e) Reproduction, recruitment, and release of family members
   f) Maintenance of Order
   g) Placement of members in the larger society
   h) Maintenance of motivation and morale
2. Influences and Impacts on Today's Families which Affect Child's Growth & Development
   a) Influences of technological changes
   b) Disruption of family units
   c) The working mother
   d) Mobile families
   e) The influence of poverty
   f) Relatives in families
   g) effects of social class upon family
3. The Family Provides the Child's Primary Experiences in Relationships & Learning
   a) Much is dependent on the dimensions of parental relationships:
      i) Degree of emotional responsiveness and acceptance
      ii) Type of control and training
      iii) Degree of valuation of the child
      iv) Level of aspiration or expectation for child
4. b) Other factors, such as child's position in the family and sibling relationsh-

Course: TECHNIQUES OF CHILD CARE

I. The Child Care Worker and His Relationship to the Individual Child
   1. The Child Care Worker's Feelings
   2. The Child Care Worker's Attitudes
   3. The Child Care Worker's Behavior
   4. The Child Care Worker's Self-Awareness

II. The Child Care Worker and His Relationship to the Group
   1. Group Structure
   2. Group Roles
   3. Group Interrelationships
   4. Dynamics of the Group Living Unit
   5. The Use of the Group Process
   6. The Role of the Child Care Worker

III. The Values in Which All Techniques of Child Care are Based
   1. The Principles of Intrinsic Rights Expressed in Terms of "NEEDS"
   2. The Principles of Individualization
   3. "Techniques" in terms of Principles of Action

IV. Routines, Schedules, and Regulations
   1. Elements of Consistency and Purposefulness
   2. Therapeutic Values
   3. Insight for Structuring and Programming

V. Discipline - Punishment - Control
   1. The Concept of Discipline
   2. Special Problems of the Beginning Child Care Worker
   3. Principles of Good Disciplining
   4. Reward and Punishment

VI. Key Skills in Working with Children
   1. Skills showing love "with no strings attached"
   2. Skills to make a child feel needed
   3. Skills encouraging a child's initiative
   4. Skills providing confidence in a child's ability
   5. Skills supporting a child toward change
   6. Skills for teaching self-control
   7. Skills for aiding emotional growth
   8. Skills for promoting social growth

VII. Some Major Dysfunctional Behaviors Found in Child-Caring
   1. Withdrawing love because of a child's misdeed
   2. Being punitive
   3. Meeting hostility with hostility: aggression with aggression
   4. Making a child the model of punishment
   5. Being a naggard
   6. Being an authoritarian
   7. Making leadership of the group a puppet to one's own wishes
   8. Being possessive of children

(Continued on next page)

(Dysfunctional Behaviors - Continued)

9. Bribing and cajoling
10. Playing one child against another
11. Competing with group leadership
12. Being inconsistent
13. Being overindulgent or overprotective
14. Subtly falling prey to unacceptable peer values of the group
15. The wrong use of group punishment

Course: NUTRITION AND HEALTH

I. Introduction To Basic Nutrition

1. Essential Nutrients
2. Functions and Sources
   a) Carbohydrates
   b) Fats
   c) Proteins
   d) vitamins
   e) minerals
   f) Fiber
   g) water

II. Meals and Meaning of Foods

1. Influence of Cultural Background and Shaping of Food Habits
2. The Pleasure Value of Food.
3. The Psychological Values of Food
4 The Social Values of Food

III. Food Habits of Children in Relation to maintaining Good Health

1. Schedules
2. Serving portions
3. Familiar Types of Food Habits Among Children in Group Care Settings

IV. Table Manners

1. How Children Learn Table Manners
2. How Children Use Table Manners to Act Out Feelings

V. The Physical Care of Children

1. Personal Hygiene and Good Grooming
2. Childhood Diseases, Illnesses, and Refferal
3. First Rules of First Aid
4. Sanitation management of physical unit

(continued on next page)

(Nutrition and Health - Continued)

VI. SEX EDUCATION

1. Creating desirable attitudes toward the child's sex and sex role
2. Normal Problems in Development
3. Guidelines for workers in giving sex information

Course: PROGRAM ACTIVITIES

I. Purposes and Values in Recreation - For All Children, But Especially for Those in Residential Care

1. Release of Tensions - Relaxation - Joy
2. Developing A Creative Approach to Problem Solving
3. Developing Skills, Aptitudes, and Pleasure from Achievement
4. Growth in Ability to Work and Play Happily with others
5. Learning to Use Leisure Constructively
6. Sensor-motor and Coordination skills

II. The Leadership Role of the Child Care Worker - Leadership by the Worker and by the Group with Guidance from the Worker

1. Relationships: To Individuals, To Children, To Groups, To Staff, Volunteers, & Supervisors
2. Tasks (alone or with others)
   a) Planning and scheduling in relation to goals for individuals and groups
   b) Listening with understanding: counseling
   c) Conducting program and guiding others in this
   d) Record keeping, including notes on individual progress
   e) Evaluation and assessment of individuals, groups, and programs
   f) Requesting, using, and maintaining supplies and equipment
   g) Improvising as needed

III. Programming - Depending on social, emotional, physical and intellectual needs of Participants.

1. Spontaneous and Planned
2. Individual and Group
3. Choosing from a wide range of possibilities

Art	dramatics	exploring	excursions
crafts	dance	nature	clubs
music	games	camping	hobbies
parties	festivals	sports	toys

IV Competition Between Individuals and Groups - A Potentially Destructive Force If Not Understood and Used Properly.

NOTA BENE: METHODOLOGY OF TEACHING THIS COURSE: DEMONSTRATION, PRACTICE, FOLLOWED BY DISCUSSION.

Course: CHILD CARE SERVICES

I. The Behavioral Sciences and the Changing Concepts in Child Care

II. Changes in Child Care Agencies Regarding:

1. Traditional Concepts - (Historical perspective)
2. New Concepts in Child Care
   a) in child rearing
   b) in the education of the child
   c) in interpretation of child's behavior
3. New Concepts in Training the Child Care Worker

III. The Child Care Worker and the Process of Change

1. Steps of the Process of Change
2. Application of Dynamics to Worker and Children under Care

IV. General Perspective in Child Welfare Services

1. Supportive, Supplementary, Income, and Protective Services
2. Day Care Services
3. Foster Care Services
4. Residential Child Care Services

V. Principles Which Underlie All Child Care Services

1. Philosophy and Value System in Child Care
   a) Intrinsic values
   b) Values expressed in terms of "Needs"
      i) Physical needs
      ii) Psychosocial needs
2. Fulfillment of These Values Through the Agency's
   a) Environmental elements
   b) Regular services
   cc) Specialized services

VI. Basic Functional Role of the Child Care Worker

1. A Parenting, surrogate Figure Providing Love, Security and Control
2. A Teacher-Guide in the Everyday Learning Situations of the Child
3. An Adult leader and Stimulator of the daily group-living process
4. A Team Worker Meeting the Needs of the Individual Child and the Group
5. Oftentimes, the Housekeeping Manager of the Group-Living Unit

VII. The Child Care Worker and the Agency

1. Integration of the Worker's Role
2. Supervision & Inservice Training
3. Appraisal of the Role

VIII. Observation and Recording

1. Daily Log
2. Individual Child Study Observation Report
   a) Conduct and behavior
   b) Relationships
   c) Personal Identification
   d) Attitudes
   e) Ways of communication
   f) Use of time
   g) Special problems and Insight

Course: UNDERSTANDING PROBLEMS OF THE EXCEPTIONAL CHILD IN GROUP CARE

I. The Exceptional Child
   1. An Overview
      a) Identification and classification
      b) Services offered:
         i) Residential care
         ii) Hospital care
         iii) Homebound care
         iv) Day care
   2. General Principles Underlying Special Placement

II. Specific Areas of Exceptionality
   1. The Child with Retarded Mental Sevelopment
      a) The Trainable Child
         i) General types of mental defects
         ii) Behavior characteristics
         III) Aspects for caring
      b) The Educable Child
         i) I.Q. and educational expectations
         ii) Behavior characteristics
         iii) Social and emotional adjustments
         iv) Aspects in caring
   2. The Child with a Neurological Handicap
      a) The cerebal palsey child
         i) Types and general characteristics
         ii) Aspects in caring
      b) The Brain Injured Child
         i) Types and general characteristics
         ii) Aspects in caring
   3. The Child with an Orthopedic Handicap
         i) Types and general characteristics
         ii) Aspects in caring
   4. The Child with a Medical Handicap
         i) Types and general characteristics
         ii) Aspects in caring

(Exceptional child- continued)

5. The Child with a Visual Handicap
   i) Types and characteristics
   ii) Aspects in caring

6. The Child with a Communication Handicap
   i) Types and characteristics
   ii) Aspects in caring
7. The Child with a Socio-emotional Handicap
   i) Types and characteristics
   ii) Aspects in caring
8. The Child Who is Educationally Retarded
   i) Types and characteristics
   ii) Aspects in caring.

APPENDIX D

FILM LIST

SEMINAR IN CURRICULUM FOR CHILD CARE TRAINING

June 15-19. 1970

FILM LIST

The following will be available for viewing during the seminar

CHILDREN WITHOUT
NEA. 1965, 30 min.
Many children in American cities are without parental love and care, without the basic requisites of daily living, without the many experiences which help them develop their potentialities. CHILDREN WITHOUT takes the viewer into a public school in Detroit where teachers and counselors establish the warm relationships such children need and provide learning experiences for them. The children are reluctant to leave at the end of the day, to return to crowded, noisy tenements where they find little understanding, food or warmth. The film shows teachers as they go into the community to visit parents, plan weekend outings, and, in myriad ways, strive to make up for the deprivation suffered by the children.

EYE OF THE BEHOLDER
Sovereign Production, 1953, 25 min.
Deals with perception and the theory that no two people see the same thing or situation in exactly the same way. A progression of dramatic events culminate with a sequence of a girl lying on a couch in the studio of Michael Gerard, an artist, with a red-stained knife at her side. What different people see as they encounter the situation and Gerard depends on their own conditioning.

DISCIPLINE AND SELF-CONTROL
B/W, 25 min. MTP #9055
This film discusses the problem of discipline as one of teaching and living with young children. The film shows how a teacher can establish control in a friendly climate and prevent disciplinary problems; discusses adequate supervision, and the dangers of over and under control, and shows how to help a child accept control. Spanish translation available. The AUDIENCE GUIDE presents for a quick preview the key principles of classroom discipline portrayed in the film. Please order in quantity from MTP Service, Ind. For discussion leaders and program directors, a DISCUSSION GUIDE AND PROGRAM MANUAL elaborating on the principles of preventing and dealing with "trouble" in the classroom, has been prepared by the Office of Child Development, HEW, Washington, D.C. 20201

JENNY IS A GOOD THING
Color, 18 min. MTP #9273
Head Start"s newest film release. Dramatically shows one of Head Start's most important concepts--that the Nutrition program plays a major role and is an intergral part of the daily activities in a quality Head Start center. A film for training staff members and introducing the best examples of the child teacher process to the community at large.

Narrated by Burt Lancaster. Title song, "Jenny", an original music score by Noel Stookey, of Peter, Paul and Mary music fame.

A Leader's Disscussion Guide (Rainbow Series #38) accompanies the film, presenting clear instructions on discussion techniques, insights into the full significance of Head Start's Nutrition Program, and suggesting questions to use in discussing the film itself. The Guide is part of the total Nutrition Kit and also may be ordered in bulk through Project Head Start, 1200 19th Street N.W., Washington, D.C., 20506. Attention: Miss Sue Sadow. Film also available in Spanish.

MY OWN YARD TO PLAY IN
National Archives, 1963, 37 min.
Photographed on the streets of New York, this film reveals the very special world children create at play, the songs they sing and the stories they tell.

ORGANIZING FREE PLAY
Vassar College Series. B/W 22 min.
MTP #9053
This film focuses on the facet of early childhood education called Free Play. Using preschool, children and their teachers in the physical surroundings of the nursey school, the film discusses these questions: What is free Play? How do children learn from free play? How does one control free play? An excellent training film also available in Spanish. An AUDIENCE GUIDE highlighting the meaning of "free play" as a curriculum of discovery may be ordered in quantity with the film through Modern Talking Picture Service, Inc. The new DISCUSSION GUIDE AND PROGRAM MANUAL, designed exclusively for the use of discussion leaders, develops in detail the salient points of "free play" philosophy. It is recommended for use with or without the film and may be ordered from the Office of Child Development, HEW, Washington, D.C. 20201.

PANCHO
Color, 24 min. MTP #9052
A Film on the experiences of the National Head Start Child of the year, Pancho Mansera, of San Luis Obispo County, California. Head Start Medical examinations found Pancho was suffering acute hypothyroidism. The film depicts Pancho, during the course of extensive medical treatment, changing from a listless, apathetic child into a happy, energetic youngster. Available in Spanish.

UNDERSTANDING CHILDREN'S PLAY
NYU, 1948, 11 min.
Pre-school children are shown reacting to many play materials in a variety of ways, thus revealing to a training observer their basic personality needs. Explains the psychological significance of children's play and the importance of observation and understanding in helping youngsters to develop physically, emotionally and socially.

WHEN SHOULD GROWN-UPS HELP?
B/W, 14 min. MTP #9018
The film points out that occasionally adult help is necessary for the preschool child to succeed in projects which he has undertaken. At other times, it is important for adults not to intrude their goals of speed or efficiency. In other words, the adult must decide whether to give the child help or not, depending on the situation and his perception of the child's needs. Four scenes follow the introduction, after which the audience is invited to decide whether the children should have been helped.

WHEN SHOULD GROWN-UPS STOP FIGHTS?
B/W, 15 min. MTP #9019
The introductory sequences in the film point out that fights, quarrels, and conflicts occur even in nursery schools which provide a peaceful and satisfying setting for the development of young children. A teacher must know her children well and must be a skilled and sympathetic observer in order to judge quickly the meaning of the conflict situation for the children involved. Four episodes are illustrated which involve conflicts among two to five year olds, although the resolution is not shown. The audience is invited to discuss the issues raised.

AND THEN ICE CREAM

GROWTH FAILURE

TO CATCH A TIGER

APPENDIX E

PUBLICATIONS LIST

SEMINAR IN CURRICULUM FOR CHILD CARE TRAINING

June 15-19, 1970

Alice Burnett
400 E. Randolph
Chicago, Illinois 60601

CAEYC - Publications
Paperback Books in Early Childhood Education
New Titles *

Quantity	Author	Title	Price	Amount
	Arnstein	WHAT TO TELL YOUR CHILD	.50	
	Barman	MENTAL HEALTH IN CLASSROOM AND CORRIDOR	2.25	
	Baruch	ONE LITTLE BOY	1.80	
	* Bland	ART OF YOUNG CHILD	2.80	
	* Cherry	CREATIVE MOVEMENT FOR THE DEVELOPING CHILD	2.25	
	* Colwell	TELL ME A STORY	.80	
	* Ferreira	THE MOTHER-CHILD COOK BOOK	2.70	
	Freud	PSYCHOANALYSIS FOR TEACHERS AND PARENTS	1.35	
	Goodman	PRIMER FOR PARENTS (pamphlet)	.60	
	Goodman	RACE AWARENESS OF YOUNG CHILDREN	1.40	
	Hymes	TEACHING CHILDREN UNDER SIX	2.90	
	* I/D/E/A	BRITISH INFANT SCHOOL (pamphlet)	.90	
	* Isaacs	INTELLECTUAL GROWTH IN YOUNG CHILDREN	2.25	
	Larrick	PARENTS'GUIDE TO CHILDREN'S READING (New edition)	.90	
	* Matterson	PLAY AND PLAY THINGS FOR PRESCHOOL CHILD	.90	
	* Piaget	PLAY, DREAMS AND IMITATION IN CHILDHOOD	1.75	
	* Pitcher	HELPING YOUNG CHILDREN LEARN	3.75	
	Rieger	SCIENCE ADVENTURES IN CHILDREN'S PLAY	1.00	
	* Simon	STEPCHILD IN THE FAMILY	.70	
	Thomas, Sister Mary	CREATIVE ART EXPERIENCES	1.50	
	* Wexler	STORY OF SANDY	.45	
			Mail	
			Total	

Note: Prices are discounted, wherever discounts are available.
Add 10¢/book ordered for mailing and handling.
Make out checks to: Early Childhood Publications

Mailing label - To _____

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_____
(Include Zip)

Contents: BOOKS

APPENDIX F

Material recommended by Dr. Robert Mendelsohn, Assoicate Professor Department of Pediatrics, University of Illinois Medical School for use in programs with paraprofessionals:

(1) Bibliographies

(2) Two Samples:

(a) If You Are Pregnant And Want Your Child
by Dr. Tom Brewer

(b) Do Big Families Reduce Disease Risk?
California Group Adds Evidence
Printed Medical Group News April 1969

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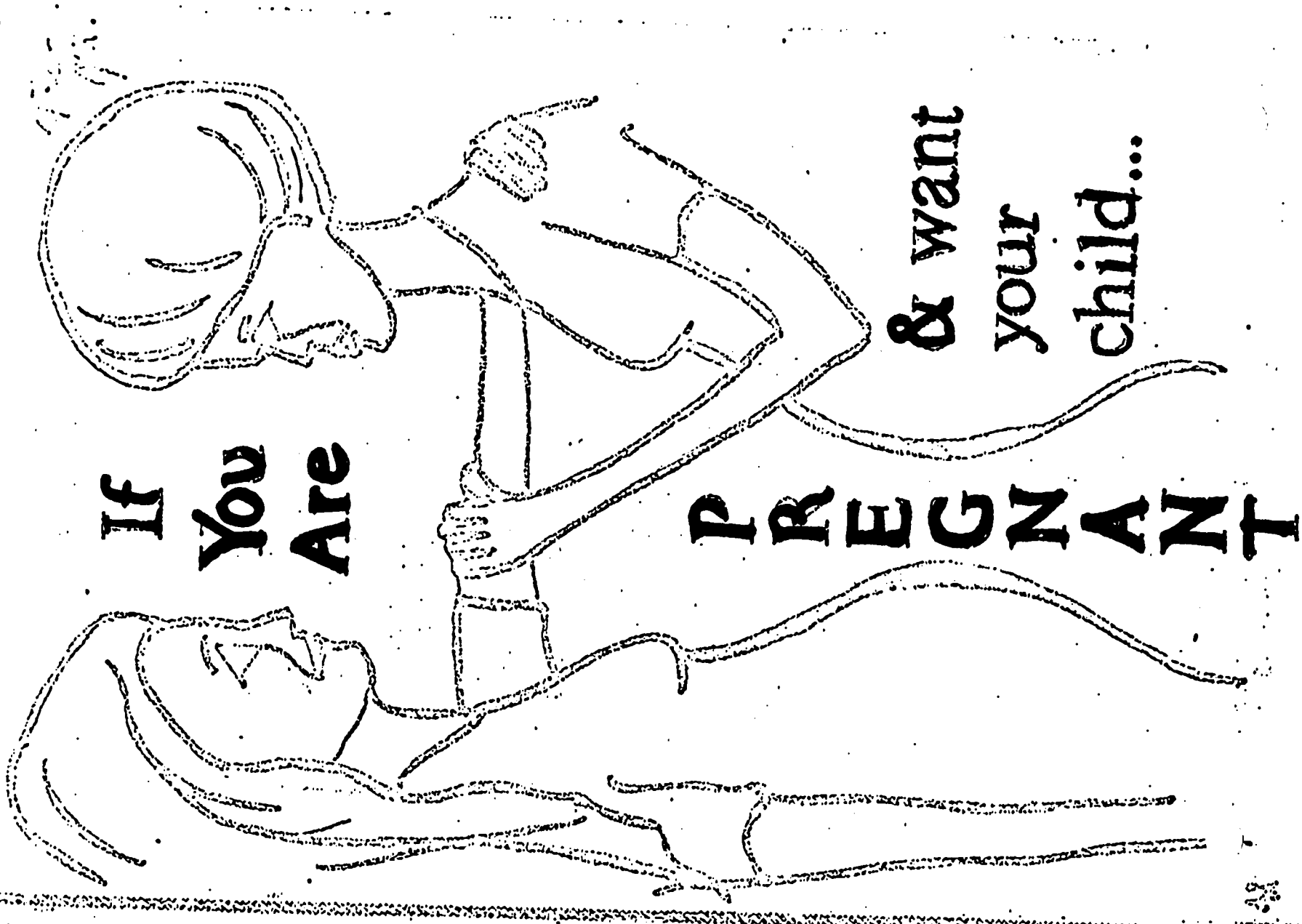


Student Research Facility
2214 Grove Street
Berkeley, California 94704

THIRD CLASS

IF YOU ARE PREGNANT...AND WANT YOUR CHILD

Introduction

You are one of over 3 million women who have a baby in the United States every year.

In recent years pregnant women in our country have been less healthy than pregnant women in many other countries. An increasing number of premature or "low birth weight" babies are being born. This is primarily caused by the failure of our doctors to recognize the role of poor nutrition in pregnancy.

Instead of emphasizing good diet, most American doctors who care for pregnant women depend on drugs such as diuretics ("water pills") and amphetamines ("diet pills"). Many doctors also use low calorie, low salt diets for "weight control."

This typical kind of treatment is often dangerous to both mother and baby. But you can avoid danger with good nutrition. The methods of diet described in this pamphlet have been used with success in my practice in 3000 pregnancies over a 6 year period.

When you understand what a good pregnancy diet is and how important good foods really are, you will be able to protect yourself and your baby from many complications. A good diet is the best insurance that your baby will be healthy and strong with a normal weight at birth.

We are asking you to help spread the message contained in this pamphlet.

The Importance of Diet

If you are pregnant you must eat a good, nutritious, balanced diet every day of your pregnancy.

The Dangers of Bad Diet

Medical science has proved the following troubles are directly caused by bad diets during pregnancy:

1. Stillborn babies
2. Low birth weight or "premature" babies
3. Babies with brain damage and less intelligence
4. Babies who get infections easier

A GOOD DIET WILL PROTECT YOUR BABY FROM THESE TROUBLES

42.

The following diseases of pregnant women are directly caused by bad diets:

1. Anemias (or "low blood") -- caused by not enough iron, vitamins and/or proteins in the diet.

   A GOOD DIET WILL PROTECT YOU FROM ANEMIAS

2. Metabolic Toxemia of Late Pregnancy (MTLP) -- a disease caused by not enough good quality proteins and vitamins in the diet. Women with MTLP suffer convulsions or "fits", coma, heart failure, shock, fat in their livers, bleeding into their livers, and often death for both mother and baby.

   A GOOD DIET WILL PROTECT YOU AND YOUR BABY FROM MTLP

3. Toxic Abruption of the Placenta or "Afterbirth" -- In this disease the afterbirth breaks loose inside the woman's womb before labor begins. The mother bleeds and the baby dies in 50% of the cases.

   A GOOD DIET WILL PROTECT YOU AND YOUR BABY FROM TOXIC ABRUPTION OF THE "AFTERBIRTH"

4. Severe infections of the lungs, kidneys and liver.

   A GOOD DIET WILL PROTECT YOU AND YOUR BABY FROM SEVERE INFECTIONS

5. Miscarriage or Abortion.

   A GOOD DIET WILL PROTECT YOU AND YOUR BABY FROM "NATURAL" ABORTIONS

What Is a Good, Nutritious, Balanced Diet?

Every day of the week you and your baby must have:

1. One quart (4 glasses) or more of milk. Any kind will do: whole molk, low fat, skim, powdered skim, or buttermilk.

2. Two eggs.

3. One or two servings of fish, liver, chicken, lean beef, lamb or pork, any kind of cheese.

4. One or two good servings of fresh, green, leafy vegetables: mustard, collard, turnip greens, spinach, lettuce or cabbage.

5. Two or three slices of whole wheat bread.

6. A piece of citrus fruit or glass of juice of lemon, lime, orange or grapefruit.

7. One pat of margerine, Vitamin A enriched.

Also include in your diet:

1. A serving of whole grain cereal: wheatena, cream of wheat, farina, or oatmeal, four times a week.

2. A yellow or red vegetable five times a week.

3. Liver once a week.

4. Whole baked potato three times a week.

What May Prevent You From Having A Good Diet

Good diet sounds simple, doesn't it? But it isn't so simple, because in our society a lot of things may happen to you to keep you from eating and digesting a good diet each day throughout pregnancy.

You may have a lot of nausea, vomiting, heartburn, indigestion, or loss of appetite.

If you do, these troubles must be corrected quickly.

IT IS NOT HEALTHY FOR YOU AND YOUR UNBORN BABY TO GO EVEN 24 HOURS WITHOUT GOOD FOOD!

HE DOCTOR (!) MAY STAND ETWEEN YOU AND GOOD UTRITION

ISINFORMATION ABOUT DIET:

You will often run into a doctor, in a ivate office or in a clinic, who doesn't ally understand this life-and-death impor- nce of a good diet for you and your baby.

You may be told nothing at all about the ed for a good diet for you and your baby.

You may be told that diet "isn't too im- ortant" for your health and for the health of our unborn child. Don't believe it.

Ycu may be told that salt, ordinary table alt, is harmful for you and your baby. Don't elieve it.

ISINFORMATION ABOUT WEIGHT GAIN:

You may be told to go on a starvation diet f you "gain too much weight." Don't go on a tarvation diet!

If you gain a few extra pounds during this regnancy from eating a good, well-balanced diet, t won't hurt you or the baby, even if you gain 0 or 60 pounds. Worry if you don't gain enough eight.

ANGEROUS DRUGS

You may be given "diet pills" to take away our appetite; drugs like Dexidrene or ampheta- ines ("_eed").

Don't take them!

These drugs are not healthy for you. They are not healthy for your unborn baby. Who would give an unborn baby "speed?" Every drug you take passes quickly in the placenta or "afterbirth" over into the baby's blood stream and body.

The amphetamines are given to kill the hungry mother's appetite. They also give her an unnatural boost. They relieve depression, make her work smoother, and make her feel that she is living a healthier life, even though she is not getting enough to eat. In this way, "speed" covers up her problem of poor nutrition.

You may be given diuretics or "water pills" during your pregnancy. The immediate effect of these pills is to cause your body to eliminate water excessively. They dry you up.

Don't take them!

These drugs are not needed to have a healthy pregnancy and a healthy baby.

These water pills have done a lot of harm to pregnant women and their unborn babies. Here are some of the bad effects of water pills in pregnancy:

1. Loss of appetite
2. Stomach irritation
3. Nausea
4. Vomiting
5. Cramping
6. Diarrhea
7. Constipation
8. Jaundice
9. Pancreatitis
10. Hyperglycemia
11. Glycosuria
12. Muscle spasm
13. Weakness
14. Restlessness

15. Dizziness
16. Vertigo
17. Paresthesias
18. Headache
19. Xanthopsia
20. Purpura
21. Photosensitivity
22. Skin rash
23. Urticaria
24. Necrotizing angiitis
25. Thrombocytopenia
26. Agranulocytosis
27. Aplastic anemia
28. Orthostatic hypotension.

The above bad effects of water pills are some of those listed by the drug companies in the advertising materials they send out to doctors or publish in medical journals.

The doctor often prescribes these drugs for normal swelling, called physiologic edema, that occurs during pregnancy.

When your feet begin to swell or the ring on your finger gets tight, it is normal if you have been eating a good, nutriticus, well-balanced diet.

Don't panic. If the swelling is a bother, lie down a few minutes on the sofa and raise your feet above your head. This will usually help. You can do it several times a day if needed.

REMEMBER: IT IS NOT HEALTHY FOR YOU AND YOUR UNBORN BABY TO GO EVEN 24 HOURS WITHOUT GOOD FOOD!

Be Alert!

PROTECT YOURSELF, YOUR UNBORN BABY, YOUR FAMILY AND FRIENDS FROM THE DANGEROUS PROMOTIONS OF THE U.S. PRIVATE DRUG INDUSTRY

The U.S. private drug industry has been widely promoting Diuretics ("water pills") and Amphetamines ("diet pills," "speed," Dexidrene) for use in pregnant women. This, along with the low calorie, low salt diet and indifference on the part of many doctors toward pregnancy nutrition, has created a grave health hazard for thousands of American women and for their unborn children. These are the methods which strangely enough have been developed to try to prevent diseases of pregnancy which we now know are caused by poor diets, by the lack of good foods during pregnancy. As a result the United States lags behind many other countries in the field of prenatal care. It is estimated that here in the United States 30,000 babies die each year of metabolic toxemia of late pregnancy, and thousands more live with damage to their brains...so that they suffer cerebral palsy, epilepsy and other nervous system disorders.

We are trying to correct this tragic situation. We want to stop the harmful nutrition practices and legal drug abuse which cause it. If you, or anyone in your family or your friend, have ever suffered from metabolic toxemia of late pregnancy (MTLP), toxic abruption of the afterbirth, severe infections in pregnancy, or if you have had a premature or "low birth weight" baby or a stillborn baby while on a starvation-type, low salt diet and water pills, PLEASE CONTACT US FOR FREE INFORMATION ABOUT HOW TO PR ECT YOURSELF AND YOUR BABY.

About The Author:

Doctor Tom Brewer has been working with pregnant women in a Contra Costa County clinic in Richmond, California, since 1963. He has carried on a program of nutrition education in the prenatal clinic serving lower income mothers who have learned how to protect themselves and their unborn babies from the nutritional complications of pregnancy. (He has reported a very low rate of premature or "low birth weight" babies born to women and girls in his nutrition education project.)

Doctor Brewer received his medical training at Tulane Medical School, New Orleans, Louisiana, and completed a residency in obstetrics and gynecology at Jackson Memorial Hospital, Miami, Florida. He practiced over 10 years in the South studying the effects of malnutrition and poverty on pregnant women and on their babies. He is the author of a number of scientific papers in national medical journals here and abroad on the subject of pregnancy nutrition. He is the author of the book, METABOLIC TOXEMIA OF LATE PREGNANCY: A DISEASE OF MALNUTRITION, Chas. C. Thomas, Publisher, Springfield, Illinois, 1966.

HUNDREDS of U.S. women die each year during pregnancy because of bad diets and unwise use of drugs. THOUSANDS of American babies die each year because of their mothers' bad diets and unwise use of drugs. You don't have to suffer these risks, nor does your baby. If you will help spread the message of this pamphlet, you can help other pregnant women protect their babies, too.

REMEMBER: IT IS NOT HEALTHY FOR YOU AND YOUR UNBORN BABY TO GO EVEN 24 HOURS WITHOUT GOOD FOOD!

IF YOU ARE PREGNANT...AND WANT YOUR CHILD

a product of

Student Research Facility
2214 Grove
Berkeley, California 94704
415-549-2172

in association with

Dr. Tom Brewer

Please direct your questions and requests to the Student Research Facility

Do Big Families Reduce Disease Risk? Calif. Group Adds Evidence

From a West Coast Correspondent

KING CITY, Calif. – The more children there are in a family, the less risk they run of contracting coronary heart disease after age 40, according to an epidemiological study conducted by a medical group practicing here among farm workers in the flourishing Salinas Valley.

Furthermore, the Southern Monterey County Medical Group study team concludes, risk factors previously associated with coronary heart disease in older persons – such as overweight, heavy smoking, and high hematocrit, creatinine, uric acid, cholesterol, and beta-lipoprotein values – also seem to drop as family size increases.

Results of the study were compiled after examination of 2,044 people representing 477 families in the district served by the valley's King City Union High School.

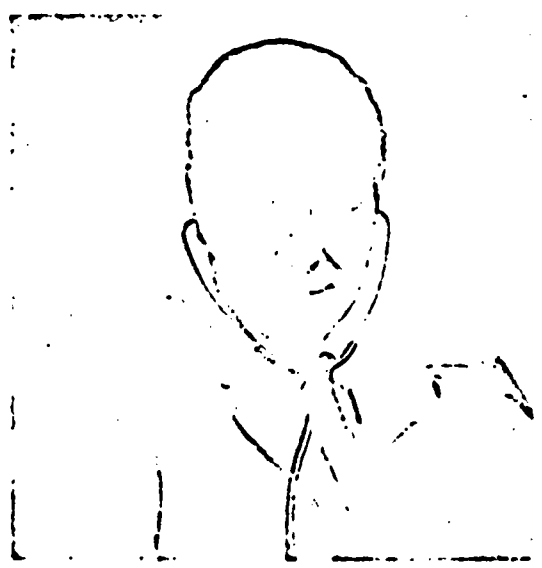
Dr. Len Hughes Andrus, director of the Southern Monterey County Medical Group, and Drs. David C. Miller and Reuel A. Stallones, also associated with the clinic during the investigation, undertook the study because they felt that "information (was) needed about the risk factors of coronary heart disease in persons below the age at which the disease becomes a major problem."

"Broken homes," they observe, "show some association with higher serum cholesterol and systolic blood pressure for children, and more smoking by mothers and children.

"If the father was missing from the family group, mother and children smoked more and had higher cholesterol values. If the mother was missing, the father had low hematocrit and serum lipids and was thinner, whereas the children had high hematocrit, serum lipids, and systolic blood pressure, and were fatter. If neither parent was present, the children smoked more, were fatter, and had higher systolic blood pressure."

Hematocrit, uric acid, serum lipids, and body fatness measurements were found to be greater in oldest and youngest than in children born in between. Serum lipids were also consistently higher in persons with a positive family history of heart disease. About a third of the study population reported some form of heart disease, coronary heart disease, stroke, and obesity in the family history. More than half had a relative suffering from hypertension. About a quarter reported one or more cases of generalized atherosclerosis, diabetes mellitus, peptic ulcer, asthma and allergic conditions, and some form of arthritis in the family (see table).

The study was supported in part by the Public Health Service, the California State Department of Public Health, the National Institute of General Medical Sciences and the Central Mission Trails Heart Association.



Andrus – "Broken homes show"

Reported History of Selected Diseases in Families of Index Persons

	Neither Mother's Father's Side	Either Mother's Father's Side	Both Parents' Sides	Percent of Families Positive
Heart disease (specific type unknown)	317	133	23	33
Congestive heart failure ("dropsy"; heart failure)	419	50	4	11
Coronary occlusion or thrombosis or infarction ("heart attack")	287	160	26	39
Angina pectoris (without thrombosis or infarction)	427	41	5	10
Generalized arteriosclerosis ("hardening of the arteries")	367	99	7	22
Hypertension (high blood pressure)	223	202	48	52
Cerebral thrombosis or hemorrhage (apoplexy; "stroke")	314	150	9	33
Diabetes mellitus ("sugar diabetes")	353	111	9	25
Obesity (overweight)	293	118	62	38
Peptic ulcer (duodenal or gastric ulcer; "stomach ulcers")	338	120	15	28
Asthma (asthmatic bronchitis)	361	105	7	24
Hay fever, hives, or eczema	343	115	15	27
Sensitivity (allergy) to foods, drugs, plants, or animals	360	95	18	24
Rheumatoid arthritis ("atrophic" arthritis) Osteoarthritis ("hypertrophic" arthritis; degenerative arthritis) Gout Other arthritis or rheumatism ("sciatica" or "lumbago")	333	119	21	29

APPENDIX G

TESTIMONY

SENATE APPROPRIATIONS COMMITTEE

ILLINOIS STATE LEGISLATURE

Robert S. Mendelshohn, M.D.

May 11, 1970

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INTRODUCTION

I come before you with mixed feelings. On the one hand, I am happy to have the opportunity to testify in this important matter, and I wish to congratulate you on holding these hearings.

At the same time, I am filled with sadness that these hearings are necessary in order to secure basic human needs for our children. This sadness is accompanied by a heavy sense of responsibility. For I did not volunteer to testify. I did not ask to be here tonight.

Rather, I was chosen by the parents of the retarded children to represent their views. They feel that you will listen to me more than you have listened to them. They feel that you will regard me as the expert. They base their opinion on the fact that for the past seven years, I have served as pediatric consultant to the Department and to Dixon State School.

I am grateful for the confidence of the parents. Yet at the same time, I am aware of the paradox of their position: for my consulting activities have been limited in time, and I have other professional and personal interests. But the parents of the retarded live with their children 24 hours a day, every day of every year.

They live with these children whether the children are at home or in a state institution. They know the children best. They are the real experts in mental retardation and mental illness. They are the ones who most deserve to be heard.

Yet, the parents are correct in assuming that the legislators are more likely to listen to me. They have therefore selected me to represent them against

the Goliath of the state. Would that I had David's skill, and courage, or even his slingshot.

However, I do possess a powerful weapon. That weapon consists of the knowledge I have acquired over these seven years from the children and from their families. I regret to admit that I have cured but few patients. My success as a healer and a helper has been disappointing to me. But I have learned much. My faculty has been the patients and their families.

I move to the main part of my testimony with a prayer that the proper words appear in my mouth so that I may serve as a faithful messenger tonight, and so that the message of the children and their families will reach the minds and hearts of you gentlemen.

HISTORY

Many remarkable changes have occurred in Dixon State School during the years I have been privileged to visit there. This is not just my opinion or that of the superintendent, Mr. David Edelson. Rather, this consensus includes the parents, the staff, the newspapers, the Mayor of Dixon and other professionals and political leaders.

I will not detail the improvements. Rather I will concentrate on what has not been done. I will focus on the unmet needs. This approach has been characteristic of my consulting activities. Seven years ago, I challenged the leadership of the School and the State Department to take the necessary measures to eradicate the epidemic gastro-intestinal diseases.

At that time, the mortality and morbidity from amebic dysentery salmonellosis, shigellosis, other diarrheas, and infectious hepatitis were disgraceful. The administration responded with improvement of sanitary conditions and with an increase in the number of employees providing direct patient care.

The situation dramatically improved and Dr. Paul Tillman, associate superin-

tendent and medical director, can provide you with figures showing that this improvement has remained over the years.

What caused the dramatic fall in deaths and sickness from diarrheal disease? I can assure you, gentlemen, it was not the provision of more paper towels or extra garbage cans, as necessary as these items were. Rather, it was from applying knowledge that has been learned in other state hospitals, that has been documented, and that has been reported in the scientific literature.

That knowledge, simply stated, is that the prevalence of diarrhea is related to the number of employees providing patient care. The fewer aides, the more deaths; the more aides, the fewer deaths.

I have related this occurrence for several purposes. The point is to indicate the nature of scientific studies. After all, couldn't any of you, or any mother present here today, have told us in advance what would happen. They know that if a child's diapers are not changed, if the staff are too overburdened to be able to wash their hands between patients, if a clean environment is not maintained, of course the children will get sick.

Yet, it is strange that the knowledge transmitted through the generations is not heeded. We seem to place more trust in studies that cost thousands and tens of thousands of dollars. (It has been correctly stated that the retarded are studied too much and cared for too little.) Therefore, my first point is a reiteration of the expertness of mothers and fathers when it comes to their own children.

The second reason for relating this event is to recommend mortality and morbidity statistics as an indicator of personnel needs. It is a rough indicator, measuring only the extremes of death and disease. Nevertheless, I would suggest to the legislators that they monitor these statistics closely. If the number of cases of amebiasis increases, or the number of deaths from hepatitis rises, one should immediately suspect that the personnel staffing pattern has dropped to a dangerously low level.

The third reason for telling this story is a personal one. You can see that I began my career with the State Department by challenging it. Those who know me are aware that I have continued to criticize its practices and policies. The Department leadership has been responsive throughout, and I have developed great respect and friendship for John Briggs. He has continued to listen to me, as has Mr. Edelson and many others, even when I spoke in opposition to their positions.

Tonight, I again must challenge the leadership. I bring this challenge with full realization of the limitations of their authority, and of their available funds. I am aware that the people who elected our representatives do not always place the needs of the handicapped, particularly the retarded, among the highest priorities. But I must speak out in order to properly repay the state for the opportunity it has given me to learn and to care for patients. I must also speak out to fulfill my responsibilities to the parents.

HOW TO PRODUCE M.R. AND M.I.

What have I learned over the years. It is true that I have acquired some new techniques of treatment and patient management. In addition, I have learned how to produce mental retardation and mental illness. With your permission, gentlemen, I would like to share this recipe with you:

1. Take large numbers of pregnant mothers and deprive them of food, so that their children will be born with small heads and fewer brain cells than our children.
2. Take other mothers and during labor and delivery give them lots of sedation, analgesic and anesthesia, so that their babies will be born blue, sleepy, unable to let out that welcome first cry; this group will show learning disorders in later life.
3. Make a large group of mothers poor and malnourished so that they will deliver 10-20 times as many premature babies as our wives

have; prematurity is closely related to mental retardation.

4. Try to break up families in many ways; use the hospitals to keep parents from visiting children, use the school teacher to tell the mother how inadequate she is; use the psychologist and psychiatrist to tell parents everything is their fault; use American industry to move executive personnel every few years from city to city. Weaken family ties and you can increase greatly the number of emotionally disturbed children and adults.
5. Place children in slum dwellings, so that they will eat lead-containing paint and thus destroy their brain tissue, if they survive at all.
6. Take students and send them away from their families to college, and then threaten them with death in a war nobody believes in; this will help produce mental illness, psychotic breakdowns, narcotic addiction and suicide. The statistics on death and disease in freshman college students is available--and it is terrifying.
7. Select a group of parents with handicapped children and refuse them the necessary facilities in their own homes and their communities to properly care for them; force them to send their children to state hospitals; make them feel ashamed, guilty, depressed and you can produce mental illness.
8. Finally, near the end of life, force vigorous men into compulsory retirement, diminish their influence, status and authority; create an inflation that will steal the food out of their mouth; close them up in old folks homes; move them from state hospitals to nursing homes and back again; do this, and you produce man-made senility, depression and mental illness.

This is part of what I have learned. In addition, I have also learned how to maintain mental retardation and mental illness once they have been produced. Here is the prescription for that process.

HOW TO MAINTAIN M.R. AND M.I.

1. Force the retarded and the mentally ill into state hospitals by failing to provide help at home.
2. Staff the state hospitals with dedicated, conscientious employees who have high motivations and strong ethical standards.

   Then give this staff old dilapidated buildings and inadequate resources; above all, deprive them of financial resources. At the same time,

   hire as few personnel as possible, assign them an impossible job, and blame them when the job is not done. This will produce frustration and eventually severe mental breakdown. The staff will lose their sense of dignity, will become depersonalized, and will be forced to hate and even mistreat the very patients they wish to help.
3. Make promises and do not fulfill them; false promises and unfulfilled expectations are a necessary part of the prescription.

These are some of the ways to maintain and extend mental retardation and mental illness. Undoubtedly, the parents as well as the legislators could add to this list.

THE PATIENCE OF THE FAMILIES

I am continually amazed at the patience of the parents and families of the retarded and the disturbed. They have come here today asking for extra millions of

dollars. Their request is reasonable. It is modest. In my opinion, it is minimal.

They have come jointly with the health professionals. As some of you know, I have concerns about professionals who ask for public money. There is always a possibility of conflict of interest. It is well known in the academic world that a pilot project can make an assistant professor into an associate professor, and extra funding can transform a professor into a chairman or dean.

But the parents have no such conflict of interest. They do not stand to gain or lose in terms of money, status, or prestige. Their interest is 100 per cent in their children. It is pure, unselfish and emanates from God alone.

Today, we are witnessing an important event--the development of a strong coalition between parents and professionals. We have come together, and we have come in a spirit of moderation and reasonableness.

REJECTED METHODS

To indicate the moderate approach of the parents, let me relate methods of appearing here in Springfield that were discussed and rejected:

1. It was suggested that the parents march on the governor's mansion (you will recall the march last year in the welfare crisis). This was rejected.
2. It was suggested that the parents take their mongoloid children from the state hospitals and visit their representatives. This was rejected.
3. It was suggested that the parents bring their hydrocephalic children and those with cerebral palsy into the Capitol building itself, so that when they defecated and urinated, the stench here might reflect for a few moments that which exists in many state hospital wards all the time. This was rejected.

4. It was suggested that the parents of children on the non-existent waiting list march with us on the State Capitol and leave their thousands of children there at the end of the day for the Governor and the Legislature to deal with. This was rejected.

5. It was suggested that we ask other groups of deprived people to join us today, including the Blacks, the students, and the senior citizens. This was rejected.

Some parents and some professionals are probably thinking in even more militant tones. Yet, the overwhelming majority are still moderate. They came here, not with non-negotiable demands, but with respectful requests. They came here not threatening, but pleading. As yet, they have not felt the depths of disappointment and despair that produces radicals out of moderates. But I plead with you--do not be fooled by their short haircuts, their beardless faces and their clean, pressed suits. Given sufficient reason, they too can be radicalized.

The list of people who feel they receive no hearing in the legislative halls of our nation is growing. The Blacks have felt discrimination for hundreds of years. So have the Spanish, the Puerto Ricans, the American Indians and the Orientals. Poor white folk from Appalachia and from Little Egypt in our state also feel no one listens to them. Senior citizens feel deprived of a place in the sun. Recent days have seen our young students increasingly turn toward radical activity.

Families of the retarded and emotionally ill are also becoming increasingly disappointed. Their slogan now reads "the advances in the care of our children depends on the extent of our anger." They are almost ready to throw off the feelings of guilt, shame and worthlessness with which many professionals have burdened them.

They are ready to say, "I am a man; my child is a human being; we are worth something; we are as good as the next person; my child deserves the same opportunities as all other children; we are all children of God."

If they are forced to join the ranks of the other deprived groups in our American society, if they later decide that more militancy is necessary to defend and save their children's lives, then we sitting here tonight will bear a heavy share of the responsibility. The future of these families rests with your action tonight and in the days to come.

PREDICTIONS

I will conclude my testimony with a few predictions of the future. These predictions are not optimistic, but I believe they are realistic. They are based on my assessment of events of the last few years as well as the present situation. I predict:

1. The legitimate request of the parents and families and their organizations will not be granted.
2. The legislature will authorize some additional money, which will be inadequate to cover the needs of all patients.
3. The legislature will not decide which patients shall receive services and which shall be deprived; rather, this kind of impossible and immoral decision will be given to the institutions and the parents.
4. The technique of "divide and conquer" will be applied. With the provision of inadequate funds the families of the mentally retarded will be pitted against those of the mentally ill; the children of the aged in state hospitals will fight with the parents of the young patients. All will fight for the meagre funds, the crumbs.
5. The "divide and conquer" technique will be extended even further. The cities will be told that more money to the retarded means less for their transit systems; the poor will be told that more

money for the mentally ill means less for the school lunch program. All the deprived groups will be pitted against each other by those presently in the seats of power.

6. Money will be voted and authorized, but not appropriated.
7. Money will be appropriated and not released (#6 and #7 are well documented by the fate of the Fawell bills).
8. There will be a few excellent pilot programs; these will be given wide publicity, so that the people will be fooled into believing that everyone is receiving the necessary service.
9. The care of the patients will not improve; their conditions may even further deteriorate; the mortality and morbidity will continue to be higher than necessary; the potential of our retarded children will not be realized and will not be developed.

THE CHALLENGE

This is a pessimistic set of predictions. But my deep pessimism is tempered by my ethical and religious conviction that this is an orderly universe and that justice will ultimately prevail.

Our choice is an ethical one. Shall we follow the philosophy of ancient Greece? In that culture, retarded children, weak infants, and elderly folks were exposed on the mountain side and left to die. The Greek ideal was beauty and society existed for the "beautiful people."

The exact opposite ethical system is that taught in the Old Testament. There we learn that all mankind were created equal, that no man is worth more than his brother, that each person is equally valuable, equally beautiful, and equally deserving of opportunities to live and to develop dignity, humanity, and nobility.

The choice is clear. Are we ancient Greek pagans or are we Christians and Jews? Do we believe our Bible or are the college students correct in their accusa-

tion that our deeds do not match our words? How long will we continue to preach non-violence while we in power daily commit violent acts--sins of commission and sins of omission--against the very children we are supposed to serve.

CONCLUSION

My challenge to you, gentlemen, and your colleagues, is to diminish the pessimism that I and the parents and others suffer from by demonstrating that we need not depend solely on divine intervention. I challenge you to show us that human agencies, such as this state legislature and other branches of our state government, can promote and achieve justice for our deprived citizens, effectively and promptly.

Thank you very much for your kind attention. I will be happy to respond to any questions you may wish to raise. However, I urge you again to pay special attention to the real experts who will be testifying later. I refer particularly to the parents of the retarded children.